CHCS Center for Health Care Strategies, Inc.

Improving the quality and cost-effectiveness of publicly financed health care

Designing Integrated Payment Systems in Medicaid

Commonwealth of Massachusetts Public Payer Commission

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CHCS
Center for Health Care Strategies, Inc.

A non-profit health policy resource center dedicated to improving services for Americans receiving publicly financed care

- **Priorities**: (1) enhancing access to coverage and services; (2) advancing quality and delivery system reform; (3) integrating care for people with complex needs; and (4) building Medicaid leadership and capacity.
- **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- **Funding:** philanthropy and the U.S. Department of Health and Human Services.
- **Medicaid ACO Learning Collaborative:** Participating states include CO, MA, ME, MN, NY, OR, WA and VT

Session Agenda

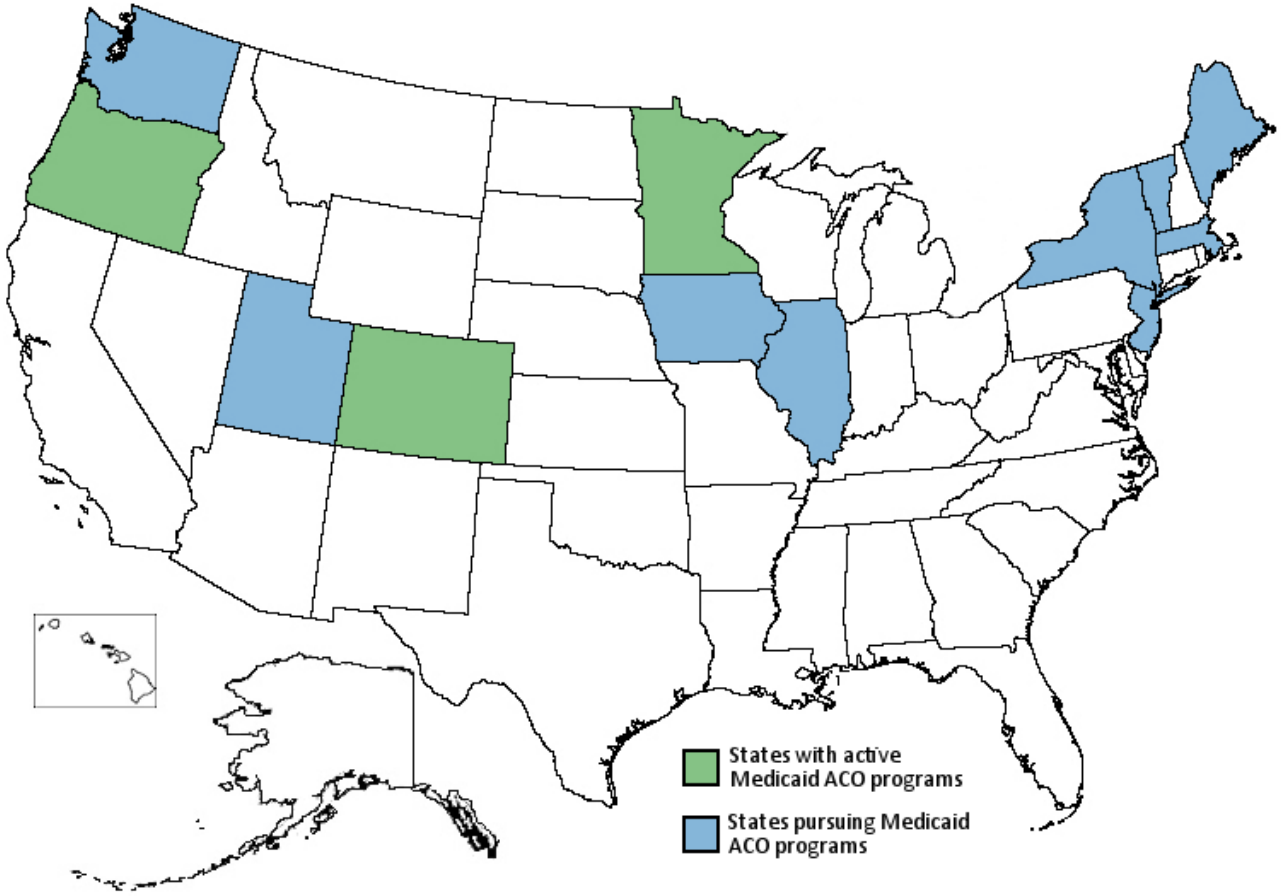
- Brief overview of emerging Medicaid ACO models
- Foundational policy decisions
- Key program design issues
- Preparing for implementation

ACO Overview

- **Key ACO features include:**
  - On the ground care coordination and management
  - Payment incentives that promote value, not volume
  - Provider/community collaboration
  - Robust quality measurement and accountability
  - Data sharing and integration
  - Multi-payer opportunities

Medicaid ACOs: A National Perspective

- Twelve states have active Medicaid ACO programs in place or are pursuing ACO initiatives



Medicaid ACO Organization Structures Vary

Provider-Driven ACOs

- Providers establish collaborative networks
- Provider network assumes some level of financial risk
- Providers oversee patient stratification and care management
- State or MCO pays claims
- **STATES**: Maine, Minnesota, Vermont

MCO-Driven ACOs

- MCOs assume greater role supporting patient care management
- MCOs retain financial risk but implement new payment models
- Providers partner with the MCO to improve patient outcomes
- **STATES**: Oregon

Regional/Community Partnership ACOs

- Community orgs partner to develop care teams and manage patients
- Regional/community org receives payment, shares in savings
- Providers partner with regional/community orgs and form part of the care team
- MCOs/states retain financial risk
- **STATES**: Colorado, New Jersey

Foundational Policy Decisions

1. **Regional vs. Provider-Driven Model**
   - Provider-based ACOs most easily leverage existing models, promote competition, easier to bring to scale
   - Regional models foster population-based approaches and efficient partnership with local services
2. **Aligning with other payers**
   - Leveraging Medicare Shared Savings Program (MSSP), Pioneer, and commercial programs promotes provider participation and lightens the lift of program development
   - Some parameters for quality and payment may need adjustment for Medicaid

Foundational Decisions *(cont'd)*

3. **Defining Relationships among Existing Initiatives**
   - Building on patient-centered medical homes and other primary care transformation models leverages existing investments
   - Ensures basic provider capabilities

Core Design Issues

1. Populations to Serve and Services to Include

- Scope depends on goals of fostering integration of physical health, behavioral health, public health, and community services
- Provider readiness to collaborate across wide network and existing collaborations
- Scope will define structural ACO eligibility requirements

Core Design Issues *(cont'd)*

2. **Designing a Payment Model Appropriate for Medicaid Populations and Providers**
   - Infrastructure → Process → Outcomes
   - Medicare shared savings methodology can be adapted for Medicaid beneficiaries
   - Global payments provide upfront funding and flexibility
3. **Defining Service Requirements**
   - Functional requirements
   - Specified activities

Core Design Issues *(cont'd)*

4. **Creating Health Plan Alignment**
   - Alignment on quality metrics and payment fundamentals
   - Fostering innovation and competition

5. **Selecting Appropriate Quality Measures and Value-based Purchasing Techniques**
   - Focus on targeted ACO goals and outcomes
   - Reflect issues unique to complex populations
   - Link payment methods to quality reporting and performance/improvement

Implementation Considerations

1. **Selective Procurement or Required Participation**
2. **Fostering Widespread Data Sharing and Analytics**
   - Robust data and analytics are critical to coordination
   - States building provider portal atop all-payer claims databases, HIE, and Medicaid claims
3. **Building ACO Functional Capacity among Providers**
   - Provider systems are not well-organized to be ACOs
   - States are investing in training and learning collaboratives
4. **Fostering Collaboration**
5. **Monitoring Mechanisms**

APPENDIX: STATE MODELS

- Minnesota
- New Jersey
- Oregon

Minnesota Health Care Delivery System Demonstration

- **Coordinates with Existing Programs** Builds on existing patient-centered medical home initiative. Patients are attributed to ACO that is affiliated with existing PCMH, if possible.
- **MCOs Required to Participate** Providers choose whether to participate. By contrast, MCOs are required to share savings with ACOs in their networks.
- **Broad Population** ACO program applies to all Medicaid beneficiaries, including adults and children, except for dual eligibles.
- **Selective Procurement** **9** organizations applied to participate in the program, and **6** were selected to participate.
- **Two Tracks for Financial Participation:**
  - ACOs formed by independent providers participate on an upside-only basis, receiving 50% of shared savings
  - Fully integrated providers bear two-sided risk, and shared losses are gradually incorporated

New Jersey ACO Demonstration Project

- **Geographic Focus**
  - Community-wide ACO model based on “hot spotting” techniques
  - ACOs are intended to serve all Medicaid beneficiaries in a specific geographic area
  - Attribution is based on where patients live, not the providers they see
  - The ACO must have the written support of all general hospitals, 75% of Medicaid PCPs and at least 4 behavioral health providers in the area
- **Financial Model Attractive to Providers.** ACOs participate on an upside-only basis, and there is no minimum savings rate.
- **MCO Participation Not Required.** MCOs have option to choose whether or not to participate in ACO program.

Oregon's Coordinated Care Organizations

- **Geographic Focus** Coordinated Care Organizations **(**CCOs) are responsible for supporting provider level payment reform, care coordination, and community engagement in 16 distinct regions.
- **Builds off Managed Care** Local Medicaid health plans banded together to form and apply to become a CCO.
- **Global Payment** CCOs receive a per patient global budget capped at a 2% annual growth rate
- **Covers Broad Range of Services and Patients** CCOs cover physical, behavioral, and oral health for all patients except dual eligibles, and have the flexibility to purchase non-medical services that will improve health.
- **Accountability** CCOs performance is measured using 33 metrics, 17 of which contribute to payment.
- **Multi-Payer Opportunities** State is exploring opportunities to align CCO requirements with health plans serving public employees and commercial beneficiaries.